**REFERRAL REQUEST**

(referral requests maybe be filled online)

Name of person supplying referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RX Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: (office telephone number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room#: \_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected Start of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEMOGRAPHICS and INSURANCE (please fax a copy of all insurance cards if available)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS #: \_\_\_\_\_\_\_\_\_\_\_\_\_ MR#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: □M □F

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Tel Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell/Home) Secondary Tel Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Following Physician and Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLINICAL INFORMATION

Primary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_

ORDERS: Received first dose: □Yes □No

Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TPN: □Pharmacy to consult with MD for formulation Duration: \_\_\_\_\_\_\_ hrs with 2-hrs ramp up/down

□PICC placement with chest x-ray confirmation □chest x-ray confirmation only

□Pharmacist to order and monitor drug levels and adjust dose accordingly

Access: □IM □SQ □Peripheral IV □Hickman □Groshong □PICC(placement confirmed)

 □Port other: \_\_\_\_\_\_\_

□Flush line with NS and/or Heparin per Las Vegas Infusion Pharmacy protocol

□Anaphylaxis kit per Las Vegas Infusion Pharmacy protocol

□Alteplase 2mg IV; leave in catheter for up to 2 hours; if still occluded, may repeat dose x1

□May start peripheral IV access, rotate sites every 3-4 days or PRN; if poor venous access, may leave peripheral IV in for 7 days and assess twice weekly

Enteral: \_\_\_\_\_\_\_\_\_\_\_\_ Rate \_\_\_\_\_\_\_\_\_ Volume: \_\_\_\_\_\_\_\_ Hours to Infuse: \_\_\_\_\_\_\_\_\_

□Pump □Gravity □Bolus □Tube Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lab Orders: □CBC with diff □BMP □CMP □Hepatic Panel □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: every \_\_\_\_\_\_\_\_\_\_ days OR \_\_\_\_\_\_\_\_\_\_week(s)

HOME HEALTH AGENCY (if no agency is specified, use Las Vegas Infusion Pharmacy nursing)

Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel Number: \_\_\_\_\_\_\_\_\_\_\_\_ Contact: \_\_\_\_\_\_\_\_\_\_\_\_

Prescriber Printed Name: NPI

Prescriber Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_